Roy Brooks
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MANAGEMENT NEEDS AND SUSTAINABILITY ASSESSMENT: FAMILY PLANNING ASSOCIATION OF TURKEY

Final Report

Family Planning Management Development (FPMD)
Project Number: 936-3055
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Office of Population, USAID

Management Sciences for Health
165 Allandale Road
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Summary of Recommendations

I. EXECUTIVE SUMMARY

The Family Planning Association of Turkey (FPAT) should be applauded for including objectives in its Mission Statement and specific projects directed at strengthening the management capacity of and information flow among Central Office staff, project personnel and Branch Volunteers. FPAT is seeking to "professionalize" the Branch systems and their operations through training of Branch Volunteers in PPBR (program planning, budget and review) and the formal development and documentation of Branch-implemented projects, both of which are new concepts for the FPAT. It should likewise be recognized for including an objective in its Mission Statement regarding diversifying its funding base.

While specific projects have well-developed, formal and documented management systems, FPAT is now at the stage where it needs to further develop its systems at the central level. The Central Office tends to rely on "informal" systems which have been successful, but which are currently burdened in light of recent additional funding and project activities. FPAT is aware it needs to strengthen systems in areas such as consolidating and computerizing service statistics/project data across all its projects, supervision of medical staff, documentation of procurement procedures/logistics manual, etc. Some of the project-level systems/models need to be "imported" into the Central Office as soon as possible and in a consolidated manner.

The Central Office seems to be working at maximum capacity. FPAT should be praised for "getting the most" out of available staff's talents, energy and commitment. However, too many FPAT personnel wear too many "hats" to ensure that a basic organizational structure exists. It would be difficult to envision any further expansion of projects, Branches or special, even one-time programs in the absence of additional specialized personnel, e.g., a Training Coordinator, IEC Coordinator, Logistics Manager, Regional Coordinators and Assistant Coordinators.

Although FPAT has had an impressive success in receiving donor funds in the last two years, it is facing a critical financial juncture within the next 18 months. By 1997, external donor funding, which currently represents over 90% of their income, will be reduced from the current commitment of $820,548 to an estimated $420,093, unless projects are extended (see table on page 20). It is likely that the UNFPA and European Union (EU) projects will be extended, but 1997 does not look too favorable without a major change or addition to current funding strategies.

FPAT is acutely aware of this dilemma, and they have identified three possible ways to generate local funding which would be of a more permanent nature. The proposals include:

1. Implementing a social marketing operation whereby FPAT would form a joint venture with a major company and sell contraceptives to generate a surplus to help support their operations.
2. Opening a "model clinic" that would provide primary health care services in addition to family planning and reproductive health.
3. Starting a training center to earn income from providing courses in family planning.

Of the three proposals, the model clinic will require the least amount of time and money to implement. If planned and designed carefully, it also has less risk than the other two proposals. The training center would most likely be dependent for sufficient financial support on a nationwide demand for training; such training programs are usually lucky if they cover their operating costs, let alone generate a surplus. The social marketing plan could certainly generate revenues, however the issue is how to do it in a manner that would either successfully compete or complement the existing social marketing programs already in operation. Given the progress of the "OK" condom enterprise, it may be particularly difficult for the FPAT to enter this market at this time and reap the same advantages of providing yet another "socially responsible" service. However, Turkey is a very large country, and the actual possibility of FPAT starting a social marketing operation may only be known if it conducts a feasibility study.

There are a number of other recommendations concerning programmatic and institutional sustainability which are highlighted in this report. Concerning financial sustainability, the main recommendation is for FPAT to obtain external funding to launch a market research and project design to implement their proposed model clinic. In addition, if funding is available, a feasibility study for the proposed social marketing program would be highly desirable.

II. BACKGROUND

The Family Planning Management Development (FPMD) Project was requested by USAID/Ankara and USAID/Washington to undertake management needs and sustainability assessments of three non-governmental organizations (NGO): The Family Planning Association of Turkey (FPAT), The Human Resource Development Foundation (HRDF), and the Turkish Family Health and Planning Foundation (TFHPF). It should be noted that the FPAT does not currently receive funding from USAID. HRDF and TFHPF receive funding for discrete project activities through USAID-funded Cooperating Agencies (CAs) working in Turkey. USAID/Ankara's objective for including the FPAT in this exercise was to identify areas where USAID might provide financial and/or technical assistance in support of the goals of its 5-year country strategy.

FPMD is a world-wide, USAID centrally-funded project implemented by Management Sciences for Health. FPMD works at the regional, national, and local levels throughout Europe, the Near East, Africa, Asia and Latin America. The project provides management assistance to national family planning programs and organizations, both public sector and non-governmental, to improve institutional and managerial effectiveness for the provision of high-quality family planning services. FPMD's approach to organizational development is built on extensive experience, which includes the provision of technical assistance to family planning organizations in over 30 countries. The project's technical areas of expertise include: strategic planning; business planning; operational work planning; financial and human resource management; management information systems; coordination and collaboration between the public and private sectors; and program evaluation.

III. OBJECTIVES

The management needs and sustainability assessment undertaken in collaboration with the FPAT is the first step in addressing the program outcomes and indicators for the NGO sector identified in the USAID strategy for Turkey. The specific objectives of the assessment were to:

1. Prepare a set of findings and recommendations regarding FPAT management systems and structures;
2. Jointly identify activities for the next 2-4 years designed to build on the FPAT's strengths, contributions to the National Family Planning Program, and objectives of its current Mission Statement; and
3. Within these recommendations and strategic activities, address the issue of the FPAT's programmatic, institutional and financial sustainability.

IV. METHODOLOGY

The management needs and sustainability assessment was undertaken during 5-8 June 1995 by Roy Brooks, Consultant in Health Finance and Management, and Alison Ellis, Regional Director, Asia/Near East, FPMD. The team undertook the following activities:

1. Prior to their arrival in Turkey, the team reviewed general background documents on the relevant economic, social and demographic indicators of development and the current status of family planning and reproductive health in Turkey. They also reviewed background documents provided by the FPAT, including its 1995 Annual Report to the Regional Council, Mission Statement, and 1995 Work Program/Budget.

2. Using questionnaires previously prepared and tested at other NGOs, the team conducted a series of interviews with key FPAT personnel, including two Board members, the Executive Director, and other senior management and project staff. Through the review of documents and meetings with staff, the team gathered information concerning:

    - An overview of the FPAT, including: history and current operations; facilities and equipment; services offered (e.g., family planning, other reproductive health, other health); information on service providers and referral systems; public education, motivation, and advocacy activities; organizational goals, policies, and strategies; organizational structure and decision-making; finances, including systems for resource allocation and costs of services; community involvement/public relations activities;

    - Key program management, and management support systems in place, including: planning (both program planning and planning for financial sustainability [e.g., fund raising]), logistics, human resource development and management, financial

management, management information systems, quality assurance and evaluation systems.

3. Ms. Ellis conducted field visits to two FPAT projects based in Ankara: The Safe Motherhood Project and the Maternal Child Health and Family Planning (MCHFP) Center. She met with the Project Coordinator, project staff, and community workers at the former, and medical staff at the latter. She also briefly visited a Ministry of Health (MOH) Health Unit operating near the Safe Motherhood Project catchment area.

See Annex 1 for the list of contacts and schedule of meetings.

Mr. Brooks and Ms. Ellis used questionnaires they developed to generally guide the interviews. Data collection was also guided by FPAT's completion of some forms prepared by the team.

On the basis of the team's review of documents, interviews with key FPAT personnel, and field visits to project sites, the team:

- analyzed the strengths and weaknesses of the FPAT in terms of its management systems and structures, within the context of its own priorities and needs, the priorities and needs of the Turkish national family planning program, and the FPAT's achievements with respect to programmatic, institutional, and financial sustainability;
- formulated recommendations to strengthen the FPAT's overall programmatic, institutional and financial sustainability; and
- recommended appropriate actions and strategies for addressing identified needs and weaknesses in FPAT management systems and structures to the Executive Director and senior management staff.

V. FINDINGS

A. PROGRAMMATIC SUSTAINABILITY

1. Strategies for service delivery

The FPAT is undergoing a period of growth in its operations and scope of programmatic activities, perhaps the most significant expansion since its founding in 1963. Between 1993 and 1995, resources from international donors nearly doubled. This is due to significant funding for discrete project activities from the EU in particular, the German Technical Collaboration (GTZ), and an UNFPA-funded subcontract from the MOH.

FPAT benefits from having a Mission Statement, developed in collaboration with IPPF, with clearly articulated goals and objectives. This document provides the guiding framework for all program activities, whether international donor-specific or FPAT's, such as the Safe Motherhood projects funded by the EU, or small-scale projects undertaken by selected FPAT Branches. This

document also guides projects focused on information, education and communication (IEC) and advocacy, such as FPAT's work with religious institutions and leaders, and its EU-funded AIDS Initiative Project which is targeting high level government (political) policy makers.

The FPAT develops a detailed annual work plan and budget. All projects are covered in this document, defined in relation to one or more of the FPAT Mission Statement's three global strategies and objectives. Each project is described in great detail, including its justification, long and short-term objectives, implementation activities, monitoring and evaluation plan, resource requirements, income, and source of funds.

Through the review of project documents, discussions with senior staff and field-based personnel, and field visits, it appears that the "target populations", i.e., the poor and under-served, men, adolescents, religious leaders, policy makers, etc. identified in the Annual Work plan are benefiting from FPAT program activities. Community-based service delivery projects, introduced by FPAT for the first time in Turkey in 1984, focus on populations living in slum areas where contraceptive prevalence rates (CPR), especially for effective methods, are low, and there is unmet need for FP and other reproductive health (RH) services. These FPAT projects are strengthening access to such services, improving client knowledge regarding all contraceptive methods, especially by addressing misinformation regarding methods, and introducing a high standard for quality of care which is client-centered and comprehensive. Moreover, FPAT is taking a leadership role at the national level, for example, through the successful introduction and replication of community-based activities which include FP and other RH services; its AIDS Initiative Project; and preparation and follow-up activities for the International Conference on Population and Development (ICPD). In sum, FPAT's various service delivery and other projects appear to be wholly consistent with the strategies and objectives articulated in its Mission Statement and Annual Work Plan. Annex 2 provides summary tables concerning the mix of services provided by FPAT.

FPAT's programmatic strategies may be categorized as follows:

- Introduction and replication of the community-based service delivery model using community women in slum areas of major cities (e.g., Adana-Mersin, Ankara, Istanbul, Diyarbakir);
- Four mini-clinics offering a range of methods and services (except sterilization, Norplant® and Depoprovera);
- IEC at the community and mass levels; and
- IEC and advocacy activities for "special" populations, e.g., adolescents, men, religious leaders, AIDS awareness among policy makers.

It is difficult to gauge the impact of the latter three activities, other than to opine that they are contributing in positive ways to knowledge, attitude and, perhaps, practice among these various general and specific groups. The AIDS Initiative Project and work with religious leaders, in particular, are important activities in light of the current lack of a national plan or strategy regarding AIDS, and recent elections in Ankara and Istanbul which have brought an Islamic

fundamentalist party to power in both cities. This latter development threatens gains to date in FP and colors the atmosphere regarding FP especially at the local level in poorer areas. (Note: since the assessment was conducted, the FPAT has informed that an all-party group established in Parliament with FPAT collaboration will be the basis for an UNFPA-funded project next year. The project will be the first initiative in Parliament to urge members to address and analyze population issues in Turkey and in the world.)

In terms of strategies for service delivery, the community-based service (CBS) model is an important contribution to national program efforts. While limited in scope (geographic area) and number of clients served annually, per se, the projects are serving poor areas not currently well served by the MOH. The impact of such a model has been well documented in countries such as Bangladesh where, as in Turkey, there is a significant gap between knowledge of FP and acceptance of methods, particularly of effective methods; there are barriers to access due to economic and cultural factors; and there is misinformation about methods. While FPAT's CBS projects are increasing access to and use of contraceptive methods (according to interviews and review of documents), and providing an opportunity for couples to switch from no or less effective methods (e.g., withdrawal) to more effective methods (e.g., IUDs, sterilization), the ultimate success and impact of these projects are wholly contingent upon the capacity and capabilities of MOH, as well as SSK and private sector, facilities to which clients are referred for the more effective methods and other RH services.

The Ankara Safe Motherhood Project, funded by UNFPA under a subcontract from the MOH, is a good case in point: women leaders working in the project's catchment area are generating demand for clinic-based services which the local MOH Health Units appear not to be able to consistently satisfy due to their own constraints, e.g., periodic lack of water, gloves, IUDs; lack of personnel trained in FP, etc. Moreover, these Health Units request a "donation" for services which many clients are unable to pay, e.g., 200,000-350,000 lire for an IUD. MOH hospitals charge 5,000,000 lire for female sterilization, which is well beyond the ability of most clients served by the project to pay. FPAT and project staff report that the quality of care at MOH Units is less than optimal. Indeed, a late afternoon visit to a MOH Health Center serving FPAT's Safe Motherhood Project in Ankara revealed a less than enthusiastic core of doctors and nurses, who acknowledged that their facility is not consistently capable of providing FP services. While the FPAT is replicating an effective service delivery model in Turkey and increasing access to services by under-served populations, the ultimate success and therefore long-term impact of these projects cannot be assured unless the MOH and other facilities are in a strong position to provide the clinical FP and RH services with trained and competent staff, equipment and supplies, and at a reasonable cost, etc.

In light of the fact that MOH Health Units are not uniformly prepared to deliver high quality services, the FPAT has employed another model in selected areas. For example, the MCHFP Center in Ankara, which serves another low income area of the city, provides a range of MCH, FP and RH services via a small clinic staff paid by FPAT: part-time pediatrician, obstetrician/gynecologist (ob/gyn) and full-time nurse. The Center used to have a community outreach component similar to that currently employed by the Ankara Safe Motherhood Project.

While the outreach component is no longer operating due to a cessation in funding, the clinic staff report no significant drop in caseload. The community is aware of the services offered and residents are able to afford the modest prices asked for services offered. However, clinic staff advise that they are capable of managing a greater caseload. Under this model, clients informed by the community workers were referred to an FPAT-"controlled" health center. Sterilization and other clinical reproductive health clients are referred from the Center to MOH or SSK facilities. The clinic staff reported similar barriers to service delivery access for clinical methods, notably that clients cannot generally afford the cost of sterilization and other elective gynecological care at MOH hospitals, and while some clients are covered by Social Security, they report less than optimal standards for quality of care at SSK facilities.

FPAT places a premium on high standards of care and respect for its clients, which is laudable. FPAT is not financially in the position to open other mini-clinics or MCHFP Centers, nor should it, given the network of MOH facilities available. While the problems of public sector capacity to manage FP caseload and quality of care issues are certainly not unique to the FPAT, nor to Turkey, the community-based information-service delivery model and the national goal of increasing CPR of effective methods is predicated on MOH facilities' capacity to adequately manage the referrals. The model and FPAT's experience to date indicate the need for constructive linkages and dialogue with MOH and SSK Provincial Health Directorate officials, at the local and central levels, which are being pursued by FPAT staff. The experience of the Ankara Safe Motherhood Project likewise indicates the need for perhaps a more strategic selection of future CBS sites on the part of the FPAT and MOH to assure that MOH Health Centers serving the targeted communities are capable of providing the FP services and services of a reasonably high quality.

A final observation on FPAT's program strategies concerns geographical coverage: FPAT's Branch structure is weak in two regions, the Black Sea Region (IV) and the East and Southeast Region (V). This may likely be attributed to the absence of approved (by IPPF) positions for Regional Coordinators in these Regions. (Note: since the assessment was conducted, the EU has approved a FPAT project in Diyarbakir. FPAT has advised that the Project Coordinator to be recruited for this new project will also serve as the Regional Coordinator, thus strengthening FPAT's activities and linkages in Southeastern Anatolia.)

2. Community and collaborative involvement

Project proposals and Branch-based projects are designed based upon specific needs identified by the FPAT. In other words, donors generally do not impose their preferences with respect to the identification of project activities or geographical location of project sites. However, the community in which the Ankara Safe Motherhood project is operating was selected in collaboration with the MOH. Needs are identified through discussions with the MOH, FPAT Regional personnel and Branch Volunteers, and municipal or other local government authorities. The level of community involvement is high, demonstrated by a number of FPAT activities and approaches. For one, the FPAT is a national association composed of Branches and Branch

Volunteers representing various geographic and socio-economic populations around the country. Second, FPAT has and is exercising a national leadership role with regard, for example, to coordinating NGOs in preparation and follow-up to the ICPD and its current AIDS-related activities with parliamentarians. Third, the Safe Motherhood projects draw upon women leaders and field supervisors from the projects' communities. Finally, the FPAT Central Office and Branches work with religious leaders in the community and religious schools.

Strengths

- The existence of a Mission Statement to guide the development of all project activities by the Central Office, Regions, and Branches.

- Comprehensive work planning based upon needs identified at the community level and through baseline surveys.

- FPAT's project activities are consistent with and seem to serve the "target populations" it has identified as priorities.

- FPAT's leadership role at the national level, collaboration with the MOH and other NGOs. FPAT appears to be fulfilling an appropriate role at the national level to the extent that its staff capacity and available funding permit. It is demonstrating appropriate standards for quality of care; the AIDS Initiative Project is "filling a gap" in national policy by increasing awareness among policy makers (politicians); and FPAT's various CBS projects are expanding access to FP/RH services, addressing misinformation, and increasing CPR, albeit on a modest scale in terms of total couple years of protection (CYP) annually. Perhaps more importantly, the CBS projects are contributing to the demonstration of the effectiveness of this model of service delivery.

- An informal examination seems to indicate that FPAT's CBS model yields a lasting impact. For example, the caseload at the Ankara MCHFP Center has not diminished despite the cessation of the community outreach component. It is presumed that the experience of FPAT's CBS projects in Ankara, Istanbul and elsewhere may yield similar results, although these projects rely on MOH facilities as referral sites.

- FPAT has developed a proposal for EU funding to replicate the Safe Motherhood Project in Diyarbakir, an area of Turkey less well served with respect to health and FP as compared to the Central and Western areas. If approved, the Project Coordinator will also serve as FPAT's Regional Coordinator, thereby strengthening its linkages and "reach" in this part of the country. (As noted above, EU approval for this project was recently received.)

Areas for Improvement and Recommendations

- Strategic selection of sites for CBS projects. The impact and effectiveness of this model, particularly for the provision of effective clinical methods, is predicated on the assurance that MOH Health Units can provide the services.

- Strategic selection of Branch projects. FPAT should examine the cost-benefit of investing considerable FPAT staff time in Branch projects which may have limited impact. It is acknowledged, however, that the FPAT Central Office is somewhat constrained in its ability to exert leverage over the Branches being that FPAT is by law a volunteer association. It is likewise recognized that FPAT has identified the "professionalization" of Branch Volunteers and Branch operations as an objective in its Mission Statement and has developed a specific project and procedures whose goal is to strengthen the management and operations of Branches.

- Challenge for the future: The FPAT should continue to address the issue of the sustainability of women leaders' motivation once project funding ceases, and to explore linkages with other local development projects or employment opportunities in which the women can become involved. For example, the Ankara Safe Motherhood Project is organizing a local bazaar at which women leaders' and clients' handicrafts will be sold.

- Funds permitting, FPAT should continue to conduct sample surveys in communities formerly served by its community-based outreach projects in order to assess whether increases in contraceptive use achieved by the projects have been sustained once the community outreach services have ended. The availability of this data is important for national policy makers as well as to present to international donors.

B. INSTITUTIONAL SUSTAINABILITY

1. Logistics

Source of commodities: Commodities are obtained from the MOH and IPPF. (See Annex 3.) Needs are estimated on the basis of the previous year's usage plus an additional percentage. The same procedures are followed for procurement of MOH and IPPF supplies. The goal is to ensure that there are no stock-outs, at which FPAT is apparently succeeding. There are no reported problems with procurement. Supplies are received once or twice a year. FPAT Branches which have clinics (3) are physically located in MOH facilities from which they can obtain supplies in a crisis. At the request of IPPF, the value of all commodities (from MOH and IPPF) is being reflected in accounting records for the first time.

Procurement guidelines: There are no written guidelines. Procedures are known to the Administrative Affairs and Finance Coordinator and his staff who maintain the system. Mr. Pamir would like to write a procurement manual, but there is no time given his current workload. He would like external assistance so that the manual reflects international standards and procedures.

Inventory control: FPAT maintains separate books for oral contraceptive (OCs), IUDs, and condoms, which are kept by the Executive Secretary. It does not maintain separate records for MOH and IPPF-donated commodities. The books note the quantities provided to Branches or projects on the basis of their requests. Inventory levels are reviewed at least twice a year, on receipt of a supply and at least one other time during the year. Stock cards are not maintained. Mr. Pamir would like to computerize the logistics system. He is currently researching locally available expertise, however there is no provision in the budget as yet for computerization of the system. In addition to any standard software, an additional computer would be required.

At the suggestion of IPPF, Mr. Pamir has just designed three forms:

- **A summary stock situation report**: the form will record the date and quantity of commodity received for each type of commodity, date and quantity shipped to a FPAT project, and balance available.
- **A stock card**: the form will record the date, source of the commodity, the quantity received, quantity shipped, and balance available for each type of commodity.
- **A request slip to be submitted by the Branch or project**: the form will indicate the type of commodity needed, the date and amount of the previous quantity requested, and the amount of the new request. The Central Office will complete the remaining information: the amount given and its value.

The forms have not yet been introduced, as they remain to be reviewed and approved by the Executive Director.

Storage and distribution: Commodities are stored at the FPAT Central Office. Additional storage space is available, as needed, at the School of Social Work with which a FPAT Board Member is associated. The storage conditions and capacity are problematic. The commodities are kept in a small supply room in which brochures, stationary, furniture, etc. are also stored. There are inadequate shelves and the boxes are not easily accessible. An expert from Korea provided assistance about 10 years ago as to how to properly store commodities, e.g., maximum room temperature, etc. These guidelines are being followed.

Commodities are distributed to Branches and projects on a "per request" basis. Cartons are packed at the FPAT Central Office and shipped via a commercial shipping agent whose office is close by, or picked up by FPAT project personnel based in Ankara.

FPAT still provides commodities to "work-based" projects which have long since expired. This is done at the request of the MOH. The MOH does not provide funding for shipping costs.

Field visits to two project sites (Ankara Safe Motherhood Project and Ankara MCHFP Center) confirmed no significant problems with the procurement and delivery of commodities (pills and condoms for the former; pills, condoms and IUDs for the latter), although supplies are distributed and used "sparingly" as the projects are aware that FPAT has "limited" supplies. The Safe Motherhood Project uses a request form to obtain supplies. The women leaders are required to

maintain stock cards of contraceptive supplies received and distributed to clients. The MCHFP Center requests contraceptives by telephone. A review of any stock control procedures was not conducted at the MCHFP Center.

Strengths

- The system in practice is "informal" with manual records, procurement practices which rely on personal relations, etc., but it appears to function effectively. Stock-outs and significant problems with procurement and distribution to projects and Branches does not appear to occur.

- There appears to be a good system of record-keeping at the project level to control supplies held by community workers.

- There appears to be an understanding of correct storage conditions.

Areas for Improvement and Recommendations

- Maintenance of the system is labor intensive, involving manual record keeping, inventory control and distribution procedures. The system is a "reactive" rather than proactive. The introduction of the proposed forms for requisition and distribution is a positive step in systematizing or formalizing current practices, and improving the flow of information (consistent with one of the goals of FPAT's Mission).

- Storage capacity is inadequate in terms of space, physical layout, shelving, user friendliness.

- Written procurement, stock card, and distribution procedures are lacking at the Central Office.

2. Organizational structure and decision making

The FPAT appears to be structured in an optimal manner that allows for effective communication. Furthermore, program managers are able to function in a decentralized manner for efficient decision making. The Central Office is very lean; no one person has a single or primary job responsibility. For an organization of approximately only 27 staff, it has been necessary for everyone to take on multiple tasks; the staff willingly contribute as much flexibility as possible in accepting a variety of responsibilities. FPAT has developed a very specific program of meetings to keep staff at all levels well informed and connected to operational decisions.

The Executive Board of Directors (BOD) is represented by 12 individuals, comprising a wide array of expertise and representation for FPAT at local and national levels. Meetings with two representatives of the Board and a review of the minutes of the Executive Board revealed that the

BOD is highly informed about the activities of the FPAT, and formally reviews and approves the annual plan and budget. The BOD feels that the most notable strength of the organization is its highly qualified management and project staff. However, they are concerned about the organization's ability to maintain funding for the management staff, since FPAT is dependent on IPPF funding which is ending shortly. Another issue raised by two of the members is that the BOD should limit its involvement to policy issues, leaving the management of operations issues to the FPAT staff.

The BOD is highly supportive of diversifying the mission of the FPAT, if this will make the organization more financially sustainable.

Areas for Improvement and Recommendations

There are approximately 11 out of the 27 full-time personnel who are supervisors and managers, yet they appear to be over burdened with numerous job responsibilities. Four possible options discussed with FPAT to address this issue were:

1. Increase decentralization of administrative and personnel issues
2. Divide job responsibilities among management staff to allow for a more focused approach
3. Continue to develop Central Office systems for client data/program statistics, accounting, and personnel in order to enable management to spend less time on these matters
4. Ensure that any additional funding includes provision for increased staff at management and supervisory levels

It is important that FPAT continue to implement some combination of the above options.

3. Planning and market research

FPAT's planning activities are very advanced: the organization has a well defined mission statement and has developed an equivalent to a strategic plan which includes specific goals and objectives, each specifying a time frame, the responsible units, and how much is budgeted for each objective. The strategic goals are translated into an annual work plan which is also very concise and easy to follow. It should be noted that the planning and budgetary process starts at the program level; projects submit their annual proposals to the central level for final approval with the BOD.

Areas for Improvement and Recommendations

The mission statement and workplan are specific at the program level. It is recommended that the third objective concerning institutional sustainability be further developed. See the financial sustainability section of this report below.

4. Management information systems

Data concerning project activities and service statistics are available; however, information is not consolidated at the central level to summarize all FPAT project outputs. There is neither a system nor individual available at the central level to maintain (manually) or enter this information into a computerized system. Detailed, computerized data systems are available and maintained at the level of FPAT's projects, but because information is not also routinely maintained in a consolidated fashion at the central level, it is not used as well as it could be for making global management decisions. The difficulty in keeping up with the service/project activity information is compounded by the fact that there are nearly 1,000 registered Volunteers with FPAT, of whom nearly 300 are active, plus there are over 23 different programs, with annual budgets ranging from $247 to over $119,000. The current MIS does not easily measure cost effectiveness or cost efficiency of operations at this time. To the extent that it can monitor activities taking place at the project level, the MIS does include data on the quality of services provided.

Strengths

- The MIS has developed in an advanced manner in the last couple of years, particularly at the project level.

Areas for Improvement and Recommendations

- The key challenge at the moment is to get project level data/systems consolidated at the central level in order to have a picture of the entire FPAT operation. This will require at least one more computer (preferably two) at the central level, and at least one part-time person available for data entry (possibly a volunteer). Additional donor funding would be required to implement this activity.

- If money can be made available, it would be highly desirable to engage a MIS consultant to develop a program allowing FPAT to implement at the central level the client registration system it has developed at the project level. The consultant could also provide the necessary training of personnel.

- There is a need to develop a computerized logistics system if FPAT is going to implement any type of social marketing program, and/or expand its current distribution of commodities.

5. Human resources development

As previously mentioned, there are 27 full-time personnel, 11 of whom are supervisors or managers, and over 300 active Volunteers. All personnel have job descriptions that were prepared jointly with an IPPF consultant. The job descriptions include major responsibilities, tasks, and job qualifications. The turnover of personnel is remarkably low—last year no positions were vacant or changed. This is likely in large part due to the team spirit present at all levels.

Personnel evaluations are done every six months, and although they are not currently in writing, FPAT is developing a formal semi-annual personnel evaluation procedure that will begin shortly. This system will include specific agreed-upon tasks that each employee will accomplish during the six-month period as well as any comments from the employee.

Salary increases are reported to be based on inflation as well as merit; however, there is no formal procedure for salary increases.

Strengths

- All the staff, certainly at the central office level, are highly qualified and dedicated individuals. There was virtually no turnover last year, and it has been impressively low during the last several years.

Areas for Improvement and Recommendations

It might be useful to have a more formal incentive plan in place for the purpose of staff motivation, although it is hard to imagine a more dedicated staff.

6. Service delivery support: quality assurance, IEC, and evaluation

Training for FPAT staff, Branch Volunteers, and project (non-medical) personnel is guided by IPPF requirements and based on IPPF standards and documents. The Project Coordinator of the Ankara Safe Motherhood Project also serves as FPAT's highly qualified lead trainer. FPAT prepares an annual training plan for Central Office, project personnel, and Branch volunteers. Training for women leaders is organized when a new project is approved by a donor. Refresher training or on-the-spot technical assistance is provided to project-specific personnel by their Project Coordinators as well as during monitoring/supervision visits by the Regional Coordinators, National Programs Coordinator and/or Executive Director. In addition, technical articles and other materials on FP and other reproductive health services are provided to all Branches and project personnel by the Central Office. FPAT does not organize clinical training activities. FPAT's four clinics are staffed by previously trained medical personnel, e.g., pediatrician, ob/gyn, nurse.

Supervision of project and Branch activities is undertaken by FPAT Central Office senior management staff and Regional Coordinators. The National Programs Coordinator and/or Executive Director cover Regions IV (Black Sea) and V (East and Southeast) as there are no approved (by IPPF) Regional Coordinators in those regions as yet. FPAT Central Office senior management staff (i.e., Executive Director, National Programs Coordinator, Administrative Affairs and Finance Coordinator, and Ankara-based Project Coordinator) have weekly meetings to review implementation issues on a project-by-project basis. Supervision is undertaken by Regional Coordinators through on-site visits to FPAT Branches. The three Branch-based MCHFP clinics are supervised by the Branch Volunteers. The Ankara MCHFP Center is

supervised by the Central Office. These meeting and reporting schedules are formal in that the requirements are documented. IPPF monitors the FPAT through semi-annual or annual program visits by London-based staff and a yearly financial audit.

This series of frequent meetings of key personnel, supervisory visits by Central Office and Regional Coordinators would seem to provide ample opportunity to review program progress, problems and constraints as against established project objectives and workplans. However, procedures and mechanisms for supervision of the quality of medical and non-medical service delivery activities are not as well developed and formalized, with the exception of CBS Project Coordinators' supervision of women leaders' outreach/IEC activities. While there are programmatic guidelines for reporting by and collection of statistics from projects and Branches, there is not a written supervisory checklist or guidelines related specifically to service delivery, other than on a project-specific basis, e.g., the Ankara Safe Motherhood Project. For example, the FPAT Central Office does not supervise the medical quality of services provided by the Ankara MCHFP Center clinical personnel.

The Safe Motherhood Project in Ankara has excellent and comprehensive project management, supervision and evaluation systems, including:

- A standardized questionnaire for the conduct of a detailed and comprehensive baseline survey of community conditions and needs, which has yielded valuable data on socio-economic conditions, FP/RH knowledge, attitude and practice, etc. in the community. This questionnaire has been and will continue to be used by community-based projects initiated by the FPAT.

- A detailed project-specific workplan which was developed based on the results of this baseline survey. Monthly workplans for women leaders are prepared by their field supervisors. House-to-house visits "target" high risk couples, i.e. no method, pre-and post-partum and post-abortion, withdrawal users.

- An approved, comprehensive FP/RH training curriculum for women leaders (community outreach workers) and their field supervisors. This curriculum was adapted from existing MOH and Population Communication Services (PCS) curricula. Again, it is a standard curriculum which may be used by all current and future CBS projects.

- A written supervision system which uses checklists and other reports, plus "spot checks" of women leaders' house-to-house activities, supplemented by weekly meetings and other frequent opportunities for review and discussion of progress, problems and obstacles to the implementation of activities. These frequent supervisory meetings between field supervisors and leader women, as well as between the Project Coordinator and field personnel also allows for on-the-spot refresher training, including role playing.

- Routine collection of data on the number of house visits, users by methods, referrals, etc. and use of this data for workplan review/adjustment, project monitoring and supervision, and routine reporting to the FPAT Central Office.

- Routine maintenance of data to track the commodities provided to and distributed by women leaders.

The National Programs Coordinator advises that the introduction of the Total Quality Management (TQM) methodology will be the focus of management development for the FPAT later this year. Moreover, an "advocacy project" on the subject of quality of care is under development. FPAT proposes to launch this initiative with a symposium to be organized by the FPAT for the MOH, SSK, and other selected hospitals. Before the symposium FPAT will arrange for training for all Turkish NGOs in quality of care issues with assistance from a local university.

IEC and counseling activities: FPAT has developed print materials (brochures, pamphlets), radio and TV spots, and has set up telephone hot lines for providing information and counseling on FP/RH services. It has also developed specialized print materials for projects directed to religious leaders and for policy makers on AIDS issues. There is no IEC coordinator or specialized IEC position at the Central Office. FPAT Central Office and Regional Coordinators contribute to the development of the print materials, and radio and TV scripts. Community-based projects use IEC print materials developed by the FPAT, as well as materials developed by others (e.g., MOH flip chart). Attempts are made to evaluate the impact of IEC activities through:

— Collecting data on the frequency of telephone calls to the FPAT offices following the airing of TV spots;

— Radio spots that include a message asking listeners to write to the FPAT providing data so the FPAT may know the socioeconomic characteristics of listeners. Recent data collection indicates that the majority of listeners are from lower socio-economic populations;

— A questionnaire provided with FPAT's book Islam and FP.

IEC and counseling undertaken by FPAT's clinics and community-based projects cover the full range of contraceptive methods, including Norplant® and Depo, which are being newly introduced into Turkey and are currently available at a very limited number of facilities in the country.

As noted above, the FPAT is making efforts to evaluate the impact of its various mass-level IEC activities. It also monitors the performance of specific projects as against established yearly objectives defined in the annual workplan, with respect to absolute numbers of personnel (e.g., women leaders) trained, services provided directly to clients, and changes in CPR. Data on the results or impact of referrals are apparently difficult to collect completely, particularly for those clients served by MOH facilities. It should be noted that it was difficult for FPAT to complete

one of the team's tables, the one on summary data for contraceptive acceptance trends over the past few years. While the information exists at the FPAT Central Office, it is in several different reports. The absence of a computerized service and project output statistics system at the Central Office certainly contributed to the difficulty in providing these data. While the FPAT has specific data on accomplishments as against specific objectives, it does not appear to have data on the impact of activities other than changes in project-specific CPR.

Strengths

- Frequent review and discussion of progress and constraints in the implementation of project activities through Central Office meetings with Regional Coordinators and Project Coordinators.

- There is a strong supervision system at project level: work planning and written supervision reviews involving the Project Coordinator, field supervisors and women leaders; "spot checks" of women leader activities and quality of service; detailed data collection, reporting and use for monitoring of activities and project management.

- A standardized and comprehensive training curriculum, adapted from existing materials, is employed.

- Refresher training is provided on-site during field visits to projects and Branches by Regional or Project Coordinators.

- Baseline surveys are used to help guide project activities.

- Formal and documented project management systems, e.g., that used by the Ankara Safe Motherhood Project, which may be replicated for rapid start-up of similar projects elsewhere in the country, particularly under the leadership or with the technical involvement of the current Project Coordinator who is highly competent and knowledgeable.

- Technical and other articles are distributed to Branches and projects.

- Effort is made to evaluate the impact of (mass) IEC activities.

- Rigorous attention is paid to quality of care. The introduction of a methodology such as TQM is a priority for this year.

Areas for improvement and Recommendations

- The development of a formal supervision system for clinical personnel, particularly since FPAT plans to open a model clinic providing all FP/RH services. In order to attract and

secure donor funds, FPAT's ability to monitor the quality of all health services provided, not just those offered by non-medical personnel, is critical.

- Decentralization of training responsibility. Inasmuch as possible, Project Coordinators recruited for any future CBS projects should have a training background/experience so that they may conduct their own training of women leaders rather than rely on the Ankara-based trainer/Project Coordinator. Regional Coordinators should continue to provide PPBR training, initial and refresher training for Branch volunteers. Moreover, linkages with local (e.g., provincial) MOH trainers and university-based training teams should be pursued to supplement FPAT training capacity.

C. FINANCIAL SUSTAINABILITY

1. Accounting and finance systems

The accounting systems are both computerized and organized at the program budget level for each project. In addition, the budget is aggregated in accordance with the three primary objectives of the organization. It is monitored in this aggregated fashion at the end of each fiscal year. Although the accounting system appears to consist of all systems such as accounts payable, accounts receivable, budget variance reports (monthly), and a balance sheet, the programs are not completely aggregated into one computerized system. For example, journal entries are done manually. Given the size of the organization, this is probably appropriate; however, computerizing the system in a completely integrated fashion will be more expedient, and will be necessary if FPAT initiates more revenue generating activities.

As previously mentioned, productivity data are available at the project level. Information is not available at the unit cost level; nevertheless, the accounting system and MIS do enable supervisors to monitor activity on an individual basis.

Strengths

- The accounting systems are both computerized and organized at the program budget level for each project.

Areas for Improvement and Recommendations

The accounting office is working very well for an institution of this size. Although it appears to consist of all systems such as accounts payable, accounts receivable, budget variance reports (monthly), and balance sheet, the programs are not completely aggregated into one. For example, journal entries are done manually. Given the size of the organization, this is probably appropriate, however, computerizing the system in a completely integrated fashion will be more expedient and necessary if FPAT will be starting more revenue generating activities in the future, particularly if it

is decided to expand clinic activities as contemplated. In addition to an integrated accounting system, FPAT should continue to have one person responsible for cash.

2. Audits

A review of the last two audits showed that the actual accounting procedures used were excellent: the 1994 audit had absolutely no recommendations to make. It should also be noted that the audit was conducted for FPAT as a whole, not just for one single project or donor-specific projects. It is clear that FPAT has a very strong and well qualified accounting and finance department.

3. Financial status and trends

Funding Sources: The FPAT has had commendable success in obtaining external donor funding. Its funding sources consist of the European Union, UNFPA, GTZ, and IPPF, and comprise over 90% of the total budgeted income for 1994. The table on the following page, provided by FPAT, illustrates trends in funding, both past and projected:

TRENDS IN FINANCIAL SUSTAINABILITY

DONOR INCOME	1993	1994	1995	1996	1997
EU	8,780	179,008	322,937	214,675	190,000
UNFPA	270	11,680	272,611	295,162	130,093
IPPF	259,318	239,600	225,000	200,000	190,000
TOTAL DONOR	268,368	430,288	820,548	709,837	420,093
TOTAL LOCAL	107,136	93,070	64,163	100,000	125,000

TOTAL INCOME	**375,504**	**523,358**	**884,711**	**809,837**	**545,093**
TOTAL EXPENSES	**368,764**	**381,940**	**884,711**	**809,837**	**445,093**
LOC INC/TOT INC	**28.5%**	**17.8%**	**7.25%**	**12.35%**	**23%**

LOC INC/TOT	**29%**	**24.37%**	**7.25%**	**12.25%**	**28%**

1993 $ = 14.385 TL – 1993 - 1994 Actuals
1994 $ = 38.250 TL – 1995 - 1997 Donor Commitments - Local Income
1995, 1996, 1997 $ = 42.500 TL
– Estimates

FPAT's external funding has nearly doubled from 1994 to 1995. While this enormous increase in outside funding has supported a corresponding increase in program activities, it also leaves FPAT almost entirely dependent on outside funding for its operations. The risk of this dependency is made greater by the downward trend in local income generation–only 7.25% of FPAT's 1995 expenses were covered by locally generated income, down from 28.5% in 1992. Moreover, the above table illustrates that FPAT projects a decrease of 39% of current external funding in less than two years. IPPF funding, which accounts for 27.5% of the 1994 budget, is scheduled to end after 1997. On the other hand it appears probable that there will be new funding following 1997 from the EU and UNFPA, which combined account for approximately 63% of the 1997 budget. However, even given this probability, 1997 does not look too favorable without a major change or addition to current funding strategies.

The detail of the diversification of funding sources can be seen from the table in Annex 4. It illustrates that 7.25% is from local sources in 1995, with 3.86% of the total income coming from fund raising activities, and 1.66% of the total income generated at the clinics; the remainder is from exchange rate differences and interest from the banks.

Over the years, FPAT has been successful in developing a fairly sustainable net worth measurable in terms of tangible as well as intangible (worth of their reputation) assets. Annex 5 is FPAT's balance sheet. It can be seen that they have a positive financial picture and have built up a lasting net worth of close to a half million dollars.

FPAT is acutely aware of the fact that they are almost totally dependent on outside funding that will probably be significantly diminished in less than two years, even when counting on the fact that the EU and UNFPA may consider new funding after this period. It is clear that unless they significantly change the composition of their funding sources, they will have to reduce both staff and programs to nearly half the current level in approximately 18 months. They have given substantial thought to this situation, and this will be further discussed in the section describing their financial strategies for sustainability.

4. Specific strategies for financial sustainability

FPAT has three distinct strategies they would like to develop and implement in the next two years to generate local income.

Strategy 1 - Social Marketing Plan. The positive aspect of this plan is that FPAT feels it has a built-in client base, derived from the clients it currently serves in its many programs. This is definitely a strong point. The risk, of course, is that social marketing is a highly competitive field; there are a

number of large companies which have already entered this market. It will therefore be a challenge to compete with companies, such as pharmaceuticals, which already have expertise in this field, and can provide contraceptives at high volume and low cost.

Moreover, following discussions with other Turkish NGOs, it is clear that this venture requires a number of prerequisites, of which the FPAT is aware:

1. A company which is willing to produce and/or supply and distribute the contraceptives
2. A significant amount of start up funds for procurement of the initial supply, market research, advertising, distribution, and employment of sales staff.

The problem is compounded by the fact that the TFHPF has already entered this venture, and it may therefore be difficult to get donors to provide start up funds for another NGO social marketing program.

Recommended Next Steps

It is necessary for FPAT to do a feasibility study as well as to prepare a formal business plan that quantitatively identifies the potential market (demand), the necessary start up costs, and the necessary infrastructure for such an operation. In addition, FPAT would have to identify a partner which has had experience with and access to several distribution points in their marketing area (e.g. pharmacies or other types of stores).

It is therefore recommended that FPAT first have discussions with USAID and/or other donors to ascertain what, if any, joint ventures can be formed, and whether or not donor funds for start-up costs could be secured.

Strategy 2 - "Model Clinic". This proposed clinic would provide family planning services, and other primary health care services, charging for the services in the form of donations. FPAT is most interested in pursuing this activity. The proposed clinic could either be an extension of one of the clinics already providing FP services, or, more likely, an entirely new clinic. Similar issues are involved here as in the case of social marketing, but the risks and start up costs should be of an entirely different magnitude—much less.

Recommended Next Steps

Obtain donor funding, if possible, to:

1. With the assistance of a consultant, conduct a market study to identify the best area to start up such a clinic, identify the client demand, and determine what should be charged for the services. (This would include development of a policy for providing services for those who can not afford to pay.)

2. Based on the market study information, determine the best array of services that should be provided in order to ensure that the operation will generate a surplus that can assist with other functions of FPAT. Services might include a pediatrician, ob\gyn, general practitioner, laboratory, pharmacy, and dental services.

3. Develop a projected budget with income and expense estimates based on the above data.

4. Consider initiating a pilot program for the Model Clinic.

Strategy 3 - Training Center. FPAT is considering the establishment of a training center where they would charge for courses based on the technical expertise the FPAT staff has acquired over the years. FPAT admits that they have not explored this option very much, and although FPAT is very skilled in its field, the risk is that they do not know what potential demand there could be for this type of operation. It was explained by the MSH team that this type of operation often only results in the ability to cover costs, and not to contribute to other operations.

Summary of Recommended Next Steps

Of the three options suggested by FPAT, the one that appears most feasible and presents the least risk is the Model Clinic. For the training center to work, it would most likely have to depend on a nationwide demand for training to support it financially. The social marketing plan certainly could generate revenues, but the issue once again is how to do it in a manner that will either successfully compete or compliment the existing competition. Given the progress of the "OK" condom enterprise, it may be particularly difficult to enter this market at this time and reap the same advantages of providing yet another "socially responsible" service. However, Turkey is a very large country. The actual possibility of FPAT starting a social marketing operation may only be known if a feasibility study is conducted.

ANNEX 1

Contacts

Dr. Semra Koral, Executive Director, FPAT
Ms. Bilgehan Yildirim, National Programs Coordinator, FPAT
Mr. Tuncer Pamir, Administrative Affairs and Finance Coordinator, FPAT
Ms. Ulber Elgin, Regional Coordinator, Central Anatolia, FPAT
Ms. Topkara Nevin, Safe Motherhood Project Coordinator, Ankara, FPAT
Ms. Nesran Ceelikkaya, Woman Leader, Safe Motherhood Project, Ankara, FPAT
Dr. Belma Tokol, Pediatrician, Ankara Mini-clinic, FPAT
Dr. Seray Oran, Obstetrician/Gynecologist, Ankara Mini-clinic, FPAT
Ms. Ayse Ozmus, Nurse, Ankara Mini-clinic, FPAT
Ms. Cemile Erol, Secretary, Ankara Mini-clinic, FPAT
Dr. Sema Kut, Dean, University of Ankara
Mr. Sabahattin Alput, previous Under-Secretary, Ministry of Finance
Mr. Edmund J. Cain, Resident Representative, UNFPA

Schedule of Meetings

5 June Team meeting with Executive Director, National Programs Coordinator, and Administrative Affairs and Finance Coordinator

6 June Meeting with Finance Coordinator re Logistics and National Programs Coordinator and Regional Coordinator re program activities and systems (Ellis)

Meeting with Finance Coordinator re finance systems (Brooks)

7 June Field visits to Safe Motherhood Project, MOH Health Unit, and Ankara Mini-clinic (Ellis)

Meeting with Finance Coordinator re personnel system, National Programs Coordinator re MIS, and Executive Director re organizational strategy and structure (Brooks)

Meeting with two Board members (Brooks)

8 June Meeting with senior management staff to discuss findings and recommendations

ANNEX 2

Table: Source and Value of Commodities, and Fees Charged

Please complete information in the appropriate boxes for your organization.

TYPE OF SERVICE	Source and Value of Commodities (Place a ✓ in the appropriate box for the source, and indicate the value)			Fee for service charged by your organization? (Circle the appropriate answer)
	Your Organization	MOH	Private Sector	
Oral Contraceptives	✓	✓	✓	**Yes No ✓**
Injectibles		✓	✓	**Yes No ✓**
Implants		✓	✓	**Yes No ✓**
IUDs	✓	✓	✓	**Yes No ✓**
Sterilization: **Male** **Female**		 ✓ ✓	 ✓ ✓	 **Yes No ✓** **Yes No ✓**
Spermicides	✓	✓	✓	**Yes No ✓**
Condoms	✓	✓	✓	**Yes No ✓**
Diaphragms, Caps			✓	**Yes No ✓**
Natural Family Planning: **Counseling** **Education**	✓	✓		 **Yes No ✓** **Yes No ✓**
Infertility: **Diagnosis** **Treatment**		✓		 **Yes No ✓** **Yes No ✓**
STDs: **Diagnosis/Treatment** **Screening only**		✓	✓	 **Yes No** **Yes No**
FP/Reproductive Health **Counseling** **Education**				 **Yes No ✓** **Yes No ✓**
Other Reproductive Health Services (please specify)				**Yes No**
•				**Yes No**
•				**Yes No**
•				

Table: Trends in Contraceptive Acceptance

Please provide the annual objective by method, and the total number of acceptors and total number of referrals for each method, by year.

TYPE OF SERVICE		1993			1994			1995 Year to Date	
	Objective	Acceptor	Referral	Objective	Acceptor	Referral	Objective	Acceptor	Referral
Oral Contraceptives									
Injectibles									
Implants									
IUDs									
Sterilization: Male Female									
Spermicides									
Condoms									
Diaphragms, Caps									
Natural Family Planning: Counseling Education									
Infertility: Diagnosis Treatment									
STDs: Diagnosis/Treatment Screening only									
FP/Reproductive Health Counseling Education									

TYPE OF SERVICE		1993			1994			1995 Year to Date	
	Objective	Acceptor	Referral	Objective	Acceptor	Referral	Objective	Acceptor	Referral
Other Reproductive Health Services (please specify) • • •									

NOTE: DATA NOT PROVIDED BY FPAT; SEE DATA ON 1994 PERFORMANCE ON NEXT PAGE, PROVIDED BY FPAT

Table: Education, Information & Training, and New Acceptors

PROJECT TITLE	FIELDWORK PERIOD	TARGET POPULATION (for new acceptors, education, information, and training	
		Targeted	Reached
WW Project, Ümraniye, Istanbul	3 months	4,143	No start given
Safe Motherhood - Ankara	3 months	2,000	No start given
Community Based FP Project, Adana/Mersin	12 months	16,544	26,722
Religious Leaders' Education Project	12 months	1,500	437
Youth to Youth Family Life & Sexual Health Project	3 months	3,786	No start given
AIDS Project: Top Level Policy Makers' Initiative	3 months	2,000	Pre-project activities started in November
Gültepe Adult Education Center	8 months	840	840
Mardin Branch Family Health Counseling Center	8 months	1,000	Baseline preparations made. No imple-mentation.
NGO Coordination Meetings	2 months	12	12
Gebze FP Counseling Project	8 months	1,500	Branch canceled project
Male Involvement (Soldiers' Education)	12 months	25,000	35,055
Information through Hotline	12 months	100,000	215,000
Telephone Counseling	12 months	5,000	126
Family Counseling & Sex Therapy[1]	12 months	2,500	260
Fairs	12 months	52,500	Over 60,000
FPAT Clinics	12 months	5,000	6,196
Radio Programs		Unpredictable	Unpredictable[2]

[1] Sex therapy part of the project was dropped.

[2] 4,500 letters were received from listeners in one year and a survey was made to assess listeners' profiles.

Table: Personnel Providing Services

Who is authorized by your organization to provide family planning and other reproductive health services? Please place a ✓ in the appropriate column if your organization currently provides and/or funds the delivery of the service.

TYPE OF SERVICE	MEDICAL DOCTOR	NURSE	MIDWIFE	PARAMEDIC	COMMUNITY WORKER
Oral Contraceptives	✓	✓	✓		✓ * If prescribed previously
Injectibles					
Implants					
IUDs	✓	✓	✓		
Sterilization: **Male** **Female**					
Spermicides	✓	✓	✓		✓
Condoms	✓	✓	✓		✓
Diaphragms, Caps					
Natural Family Planning: **Counseling** **Education**	 ✓ ✓	 ✓ ✓	 ✓ ✓		 ✓ ✓
Infertility: **Diagnosis** **Treatment**	 ✓				
STDs: **Diagnosis/Treatment** **Screening only**	 ✓				
FP/Reproductive Health **Counseling** **Education**	 ✓ ✓	 ✓ ✓	 ✓ ✓		 ✓ ✓
Other Reproductive Health Services (please specify) • • •					

Table: Services Provided

Please place a ✓ in the appropriate column for service delivery if your organization currently provides and/or funds the provision of the service.

TYPE OF SERVICE	CLINIC BASED	COMMUNITY DISTRIBUTION	IEC ONLY	REFERRAL TO OTHER SERVICE
Oral Contraceptives	✓	✓		✓
Injectibles			✓	✓
Implants			✓	✓
IUDs	✓			✓
Sterilization: **Male** **Female**				✓
Spermicides	✓	✓		
Condoms	✓	✓		✓
Diaphragms, Caps			✓	✓
Natural Family Planning: **Counseling** **Education**	✓	✓		
Infertility: **Diagnosis** **Treatment**	✓			✓
STDs: **Diagnosis/Treatment** **Screening only**	 ✓			✓
FP/Reproductive Health **Counseling** **Education**	 ✓ ✓	 ✓ ✓		 ✓ ✓
Other Reproductive Health Services (please specify) • • •				

Table: Source of Training for Personnel

Please circle **Yes** or **No**, according to whether or not your organization provides training for the personnel listed.

Staff Category	Initial or Refresher Training Provided by Your Organization?
Department Manager	Yes ✓ No
Program Manager	Yes ✓ No
Project Coordinator	Yes ✓ No
Medical Doctor	Yes No *
Nurse	Yes No *
Midwife	Yes No *
Paramedic	Yes No
Counselor	Yes ✓ No
CBD Agent	Yes ✓ No
Outreach or Community Worker	Yes ✓ No
Community Volunteer	Yes ✓ No

* FPAT recruits trained doctors, nurses and midwives, but also may provide training if necessary in any specific field.

ANNEX 3

ANNUAL REPORT
ASSOCIATION: FPA Turkey

CONTRACEPTIVES

FORMAT "E1"
YEAR: 1994

TYPE/BRAND :
UNIT : I U D

	ACTUAL Quantity	APPROVED BUDGET Quantity	VARIANCE between ACTUAL & BUDGET
1. Stock at 1 January	6 213		
2. Received/Requested through IPPF	1 600		
3. Received/Expected from other sources	___		
4. Issues to Association acceptors	*807* ~~782~~		
5. Issuses to Other Agencies (please specify)			
6. Other Issues (incl losses, etc. : please specify)			
7. Stock at 31 December (Lines 1, 2 and 3 less lines 4, 5, and 6)	*7 006* ~~7 031~~		

TYPE/BRAND :
UNIT :

1.	Stock at 1 January			
2.	Received/Requested through IPPF			
3.	Received/Expected from other sources			
4.	Issues to Association acceptors			
5.	Issuses to Other Agencies (please specify)			
6.	Other Issues (incl losses, etc. : please specify)			
7.	Stock at 31 December (Lines 1, 2 and 3 less lines 4, 5, and 6)			

COMMENTS: Use a separate sheet of paper and attach it to Format "E1"

ANNUAL REPORT
ASSOCIATION: FPA Turkey

CONTRACEPTIVES

FORMAT "E1"
YEAR: 1994

TYPE/BRAND :
UNIT : CONDOM

	ACTUAL Quantity	APPROVED BUDGET Quantity	VARIANCE between ACTUAL & BUDGET
1. Stock at 1 January	243 480		
2. Received/Requested through IPPF	70 000		
3. Received/Expected from other sources	150 000		
4. Issues to Association acceptors	174 800		
5. Issuses to Other Agencies (please specify)			
6. Other Issues (incl losses, etc. : please specify)			
7. Stock at 31 December (Lines 1, 2 and 3 less lines 4, 5, and 6)	290 680		

TYPE/BRAND :
UNIT : ORAL PILL

		ACTUAL Quantity	APPROVED BUDGET Quantity	VARIANCE between ACTUAL & BUDGET
1.	Stock at 1 January	13,490		
2.	Received/Requested through IPPF	5,262		
3.	Received/Expected from other sources	___		
4.	Issues to Association acceptors	6,672		
5.	Issuses to Other Agencies (please specify)			
6.	Other Issues (incl losses, etc. : please specify)			
7.	Stock at 31 December (Lines 1, 2 and 3 less lines 4, 5, and 6)	12 080		

COMMENTS: Use a separate sheet of paper and attach it to Format "E1"

ANNEX 4

Table: Financial Sustainability

Revenue Generating Activity	Annual Revenue Projected	Annual Expenses Projected	NET Revenue After Expenses	% of Total Revenue
1. Client Services	$	$	$	
a. Clinics				1.66
b. Laboratories	14,691	9,377	5,314	
c. Other				
2. Private Sector Activities				
3. Reduction of Expenses				
4. Reduction of Services Provided				
5. Partnerships with Other Organizations				
6. Outside Consulting or Training				
7. Outside Donors		$		
Name and expiration date				
IPPF	225,000	225,000	—	25.43
Name and expiration date				
EU (IPPF) (WW Adana/Mersin)	119,847	119,847	—	13.55
UNFPA (Safe Motherhood/Ankara)	85,540	85,540	—	9.67
EU (AIDS)	74,672	74,672	—	8.44
BMZ (GTZ)	479,369	179,369	—	20.27
EU (Safe Motherhood/İstanbul)	128,418	128,418	—	14.52
UNFPA (Panels)	7,792	7,702	—	0.87
8. Selling Technical Products (software, manuals, books)				
9. Commercial Marketing (sales from contraceptives, etc.)				
10. Fund Raising (Resource Development)	34,144	15,000	19,144	3.86
11. Other	15,328	39,786	-24,458	1.73
TOTAL	884,711	884,711	—	100.0

ANNEX 5

Balance Sheet

Family Planning Association of Turkey
1994

ASSETS	AMOUNT	LIABILITIES	AMOUNT
CASH	0	CUMULATIVE DEPRECIATION	930
BANKS	92,819	OTHER LIABILITIES	7,461
RECEIVABLES, PERSONNEL	1,036	TAXES DUE	12,132
RECEIVABLES, OTHER	845	SOCIAL SECURITY DUE	1,477
INVENTORY	1,072	SAVINGS PROMOTION FUND	452
BUILDINGS	7,283	SEVERANCE PAY FUND	4,6888
FIXED ASSETS	3,172	V.A.T. DUE	229
GENERAL EXPENDITURES ACCOUNT	363,123	TERM INCOME	419,842
TOTAL	469,350	TOTAL	469,350